CHILD'S PROFILE

The following information will help us to better understand your child and his / her needs. 1. ARE THERE ANY KNOWN SPEECH, HEARING OR VISION DIFFICULTIES?						
. ARE THERE ANY MEDICAL PROBLEMS THAT REQUIRE SPECIAL ATTENTION OR OF WHICH WE SHOULD BE AWARE?						
DOES YOUR CHILD DISPLAY ANY EMOTIONAL FEARS, BEHAVIOR PROBLEMS OR DIFFICULTIES IN DEALING WITH OTHERS?						
. DOES YOUR CHILD RECEIVE ANY SPECIAL SERVICES THROUGH SCHOOL?						
5. IF YOU COULD DESCRIBE YOUR CHILD IN ONE PHRASE, WHAT WOULD IT BE?						
6. WHY DO YOU WANT YOUR CHILD IN THIS PROGRAM?						
7. ACTIVITIES YOUR CHILD CANNOT PARTICIPATE IN?						
8. IS THERE ANYTHING ELSE WE SHOULD KNOW ABOUT YOUR CHILD?						
DADENT / OUA PRIANI A OREFINENT						
PARENT / GUARDIAN AGREEMENT						
I, the undersigned, hereby enroll my child,						
I have provided the staff with pertinent, complete and correct information which may assist the Volunt child, including, but not limited to: allergies, pervious or existing illnesses or conditions, sunburn sensitivity disabilities or limiting conditions, emotional development or behavioral difficulties.						
The Volunteer Internship Program for my child begins when the child has reached the program and che Program staff person.	ecked in with a Volunteer Internship					
It is my responsibility to arrange for my child to be picked up at dismissal time. If my child is not picked have failed, another authorized person will be contacted. If all attempts to contact an authorized person to Internship Program will contact Child Protective Services and/or police officials.	•					
I hereby give permission to record the image and/or voice of my child for newsletters, special projects releases. I understand that I will not be informed or reimbursed for such photographs or videos.	, brochures, web sites or newspaper					
Should a person arrive to pick up my child who appears to be under the influence of drugs or alcohol, for recourse but to contact the police.	or the child's safety, staff may have no					
The Volunteer Internship Program is mandated by the state law to report any suspected cases of child authorities.	abuse or neglect to the appropriate					
My signature acknowledges my understanding of, and agreement to the above and that all information	n I provide is accurate and complete.					
PARENT / GUARDIAN SIGNATURE	DATE					
PARENT / GUARDIAN NAME- PRINTED	RELATIONSHIP TO CHILD					

2007 PARENT INFORMATION APPLICATION

Volunteer Internship Program

Volunteer Internship Program "VIP" is a community program that rewards students ages 12-14 with volunteer opportunities that expose them to the world of work.

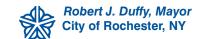
Who's Eligible?

City of Rochester youth currently enrolled in high school, ages 12-14, who have a 2.0 ("C" average) or higher GPA for the current parking period, have minimum 90% school attendance for the year, and have not had a long-term (five days or more) suspension during the school year.

Where to Apply?

Youth Services 80 Commercial Street Rochester, NY 14614 585-428-6448





CHILD / FAMILY INFORMATION

To be comple	ted by parent/gua	ardian. Please comple	ete al the inforn	nation (printing clearly in	black or blue ink) and sign where required.	
CHILD'S NAM	ЛЕ		NICKNAN	ΛC	STUDENT ID #	
MALE	FEMALE	BIRTHDAY			STODENT ID #	
SCHOOL ATTE	NDING					
CURRENT GRADE		ATTACH A COPY OF MOST RECENT REPORT CARD				
• A 2.0 ("C" a	0% school attendar	GPA for the current mar	rking period.			
HOME ADDR	ESS				ZIP	
HOME TELEP	HONE NUMBER ()		LANGUAGES SPOKEN AT	HOME	
		PAREN	T / GUARD	IAN INFORMATIO	ON	
MOTHER/GU	ARDIAN NAME			FATHER / GUARDIAN NAM	ΛΕ	
ADDRESS				ADDRESS		
HOME PHONE				HOME PHONE		
WORK PHONE	<u> </u>			WORK PHONE		
PLACE OF EM	PLOYMENT			PLACE OF EMPLOYMENT.		
	EMER	GENCY INFORI	MATION / (CHILD PICK-UP A	UTHORIZATION	
child. I agree to p	pay all of the costs asso emergency, and the Vol egarding the care of m	ciated with the emergency lunteer Internship Program s	medical care that m staff are unable to re	y child receives. each the parent/guardian listed al	o Program to obtain the necessary medical care for my bove, the following individuals have permission to ogram in case of an emergency or dismissal	
NAME				NAME		
RELATIONSHII	P TO CHILD			RELATIONSHIP TO CHILD		
HOME PHONE		WORK PHONE _		HOME PHONE	WORK PHONE	
ADDRESS				ADDRESS		

HEALTH INFORMATION

Operations

Hearing

Indicate YES where it applies and explain as necessary below

Asthma

Diabetes	Vision	Hay Fever						
Special Diet	Illness	Poison Ivy						
Convulsions	Injury	Insect Bite Allergies						
Physical Restrictions	Psychological / Emotional	Medication						
Learning Disabilities	ADD / ADHA	Food Allergies						
Allergies	Other	Other						
PLEASE EXPLAIN ALL YES ANSWERS FROM ABOVE:								
IS YOUR CHILD CURRENTLY TAKING PRESCRIBED OR OVER-THE-COUNTER MEDICATION? YES NO IS YOUR CHILD COVERED BY ANY HOSPITALIZATION / MEDICAL CARE POLICY? YES NO								
Please provide a copy of your hospitalization card. (A copy can be made by staff for your convenience.)								
MEDICAL DOCTOR								
ADDRESS								
PHONE NUMBER								